Medicare Pulmonary Rehabilitation Update – 2022

The Centers for Medicare and Medicaid Services (CMS) made several changes to the pulmonary rehabilitation (PR) benefit in its update to the 2022 physician fee schedule (86 FR 65244 – 65250). CMS acknowledged the similarities between PR and cardiac rehabilitation (CR) programs and made conforming changes to enable stakeholders with interest in both programs to compare requirements and implement programs more easily. Revisions to definitions and regulatory text now align and conform to CR programs. Following are noteworthy changes as outlined in the final rule.

COVERAGE EXPANDED TO INCLUDE COVID-19

In addition to individuals diagnosed with moderate, severe, and very severe COPD (e.g., GOLD classification II, III, and IV), as of January 1, 2022, PR coverage has been expanded to include individuals with suspected or confirmed COVID-19 who experience persistent symptoms that include respiratory dysfunction for at least 4 weeks. Hospitalization, a positive COVID-19 test, pulmonary function test, or direct physician contact are not required for the person to be covered. Coverage of PR still includes up to two, one-hour sessions per day up to 36 sessions within a 36-week timeframe. An optional 36 sessions can be approved over an extended period by the Medicare Administrative Contractor, but the total number of sessions overall cannot exceed 72. Individuals who do not meet the PR criteria of COPD or COVID-19 receive individual respiratory care (respiratory therapy services) that are billed using codes G0237, G0238 and G0238.

NEW CPT CODES

G0424 has been replaced with two new CPT codes:

- **CPT 94625:** Physician/other qualified health care professional services for outpatient PR; *without* continuous oximetry monitoring (per session)
- **CPT 94626:** Physician/other qualified health care professional services for outpatient PR; *with* continuous oximetry monitoring (per session)

CMS has stated in final rulemaking that the refinements to the practice expense inputs used to establish payment are based on the belief that 100% of the utilization for PR services previously billed using G0424 will now be billed using CPT code 94626, i.e., *with continuous pulse oximetry monitoring* (86 FR 65114). AARC and other pulmonary groups that include AACVPR disagreed with CMS and submitted examples of when it would be appropriate to use CPT 94625. Based on stakeholder comments, CMS will consider the information received regarding utilization of the two codes in future rulemaking but did not change their final assumption.

Commercial and private payors vary in both PR policy coverage and reimbursement. For example, we are aware that some insurance companies only pay for continuous monitoring, even though the payment amount is the same for each code when services are furnished in the hospital outpatient setting. This policy may stem from CMS comments about billing CPT 94626 100% of the time. It is especially important to check with specific insurance payors when submitting claims to make certain treatment and billing are appropriate, as well as to avoid potential issues with audits.

Because there continues to be confusion, AACVPR has developed the following information, including a pulse oximetry monitoring algorithm, that may assist programs in their clinical judgment as to when to differentiate or select CPT 94625 versus CPT 94626. They have graciously allowed AARC to provide the information to our members to reach as many programs as possible.

USE OF CODES *WITH OR WITHOUT* CONTINUOUS PULSE OXIMETRY MONITORING BASED ON CLINICAL NEED

Determining which code is appropriate is up to the discretion of the program's medical director in consultation with the program staff. Your program will want to keep with evidence-based guidelines, best practice and value-based care based on clinical need for each patient. The following information is meant to provide guidance to programs about the appropriate use of PR codes based on clinical needs.

Without Continuous Pulse Oximetry Monitoring (CPT 94625)

If the patient's condition does not require continuous oximetry, that would mean intermittent, or no pulse oximetry is clinically indicated for that patient. It is not appropriate to use CPT 94626 in those circumstances.

Table 1. Examples of intermittent use or no clinical need for pulse oximetry
• Some patients may never desaturate or rarely desaturate as they progress through the PR sessions.
• With the goal of self-management, tapering oximetry monitoring is appropriate in some patients who improve enough not to require continuous observation of oxygen saturation levels.
• Some patients may require monitoring of blood pressure or blood glucose or other physiologic or psychological measurements instead of oximetry monitoring.

Continuous Pulse Oximetry Monitoring (CPT 94626)

Even though reimbursement is the same for the two codes in the hospital outpatient setting, it is important to provide thorough documentation of the patient's clinical need for continuous oximetry monitoring to support use of CPT 94626.

Table 1. Possible patient indications for continuous pulse oximetry monitoring
• COPD dx stage 3-4 to assess for exercise-induced hypoxemia or inadequately treated, warranting changes in flow setting or delivery equipment or both
• COPD patient with recovery from recent exacerbation
• Post COVID patient on oxygen therapy to transition off
• Post COVID patients who exhibit pulmonary fibrosis or history of pulmonary embolism
• COPD or post COVID patient with co-morbidities – pulmonary hypertension, cor pulmonale, cardiac dysfunction, arrhythmia, erythrocytosis, anemia
• COPD or post-COVID patient with tracheostomy or transtracheal oxygen catheter (TTO)

Table 2. Changes in oxygen interfaces/equipment that may indicate need for continuous pulse oximetry monitoring
• Change in oxygen interfaces – including nasal cannula, oxymizer cannula or pendant, oxymask
• Change in equipment – patient's portable oxygen concentrator (POC), Life2000 (L2K), Tidal Assist Ventilator (TAV Sidekick) or BiPAP

PULSE OXIMETRY MONITORING ALGORITHM

The following is an example of a pulse oximetry monitoring algorithm that may help in the clinical judgment for differentiation and selection of 94625 versus 94626, or your program may develop its own.

1. Oxygen Assessment: Patient's oxygenation status should be assessed at the initial evaluation prior to starting the program (with 6MWT), during supervised exercise sessions and on the discharge assessment (with 6MWT). (AACVPR 5th edition) This will help determine if the patient may require continuous pulse oximetry monitoring.
    a. If the patient has an oxygen prescription, continuous pulse oximetry on prescribed equipment may be warranted. Assessment may reveal that hypoxemia is inadequately treated, warranting changes in flow setting or delivery equipment or both. (AACVPR 5th edition, ATS).
    b. The patient should be educated on how and when to use their prescribed oxygen systems. (AACVPR 5th edition, ATS)
2. Patient education: Inform the patient that use of continuous pulse oximetry may be needed and will be discontinued within a few (i.e., 2-4) sessions, if their treatment is proceeding as anticipated and no longer indicating need for continuous pulse oximeter monitoring.
3. Exercise Training: The patient indicating the need for continuous pulse oximetry monitoring may need the first 2-4 sessions of PR, as clinically indicated. Characteristics of patients who may need continuous pulse oximetry are listed in Table 1 and 2.
4. Following 2-4 sessions of PR, patients without indicators for continued pulse oximetry are transitioned to intermittent pulse oximetry monitoring. The exercise intensity is guided by patient's rating of perceived dyspnea and exertion (RPD/RPE), heart rate and BP response.
5. Pulse oximetry needs will differ for each patient depending on their specific situation. It may be appropriate to switch between continuous and intermittent oximetry monitoring sessions throughout rehab. Rehab professionals should critically assess patient needs each session and use clinical judgement to determine appropriate use of pulse oximetry.

Resources:

- American Association of Cardiovascular and Pulmonary Rehabilitation. Guidelines for Pulmonary Rehabilitation Programs. 5th ed. Champaign, IL: Human Kinetics; 2020. https://us.humankinetics.com/products/guidelines-for-pulmonary-rehabilitation-programs-5th-edition-with-web-resource
- Jacobs, SS, et al. "Home Oxygen Therapy for Adults with Chronic Lung Disease. An Official American Thoracic Society Clinical Practice Guideline." American journal of respiratory and critical care medicine. Vol. 202,10 (2020): https://doi.org/10.1164/rccm.202009-3608ST
- "Post-COVID Conditions: Overview for Healthcare Providers." Centers for Disease Control and Prevention. Updated July 9, 2021. https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-care/post-covid-conditions.html

VIRTUAL PULMONARY REHABILITATION SERVICES

Hospital Outpatient PR

Under the Hospital Without Walls waivers allowed during the PHE, patients can receive services via two-way, real-time audio/visual telecommunications in their home. Certain conditions apply, e.g., the patient must be registered as an outpatient, and the hospital must have approval to designate the home as a provider-based department of the hospital to be reimbursed for PR services. Although hospitals typically cannot bill for telehealth services, hospitals are allowed to bill for virtual PR services as though the services were furnished in the hospital outpatient setting until the PHE ends.

Physician Office PR

Although physician office-based PR only accounts for about 2% of all programs, CMS has added the new CPT PR Codes to the list of covered telehealth services provided in the physician office setting through December 31, 2023. These services are included as Category 3 codes which are temporary codes for which CMS seeks data to determine if they should be added to the list permanently.

VIRTUAL DIRECT PHYSICIAN SUPERVISION

The statute requires the supervising physician to be immediately available and accessible for medical consultations and medical emergencies at all times items and services are being furnished, although the physician is not required to be in the room where the service is being furnished. For the duration of the PHE, the physician can meet the direct supervision requirement via real-time, two-way audio/visual telecommunications technology (excluding audio-only). CMS is considering whether to make this provision permanent in future rulemaking.

Separate from the *virtual* direct supervision issue, it is important to note direct supervision will be expanded to include physician assistants, nurse practitioners and clinical nurse specialists, effective January 1, 2024. However, Congress has introduced a bill that will move the date to 2022, if enacted.

INDIVIDUALIZED TREATMENT PLAN (ITP)/MEDICAL DIRECTOR

The statute requires the ITP to be established, reviewed, and signed by a physician every 30 days. CMS provided a detailed discussion in its final rule about the challenges of meeting these requirements which may be helpful for our members. They are highlighted here for your convenience.

The definition of "medical director" has been revised to mean "the physician who oversees the PR program *at a particular site*." The medical director and any staff physicians(s) working in the PR program who participates in the patient's care and has knowledge related to the patient's condition, or the patient's treating and/or referring physician may establish, review and sign ITPs. If all requirements are met, "a separately billable E/M service may be furnished by the medical director or other PR staff physician(s) working in the program in connection with establishing and signing the ITP on or before the first day of PR." Physicians treating cardiopulmonary conditions who are not staff of the PR are not precluded from developing and signing ITPs for their patients before they begin PR. ITPs developed and signed on or before the first of PR by a physician who is treating the patient's respiratory condition outside of the PR program should be reviewed by the PR medical director and other appropriate staff, but an additional signature from them is not required. The medical director or other physician working in the program, in consultation with staff (e.g., respiratory therapists) may revise the ITP as needed to ensure the plan is appropriately individualized, regardless of which physician establishes and signs the plan.

DIRECT PHYSICIAN-PATIENT CONTACT

The requirement that the physician have "direct patient contact related to the periodic review of his or her treatment plan every 30 days" has been removed as overly burdensome and unnecessary. According to CMS, the need for direct physician-patient contact can be written into an ITP for patients who require such attention since a physician is already required to review the plan every 30 days in consultation with PR staff. PR staff track a patient's progress at each session and can identify the need for direct physician-patient contact as appropriate. Additionally, patients participating in PR continue to have ongoing interactions with their treating physicians outside of PR.

2022 PAYMENT RATES FOR PR/RESPIRATORY THERAPY SERVICES

Below are the rates that were included in the final Calendar Year 2022 updates to the physician fee schedule and the Ambulatory Payment Classification (APC)Groupings paid under the hospital outpatient prospective payment system. Minor updates are made on a quarterly basis as additional claims are processed.

Service	Procedure Code(s)	APC	Payment	Co-Pay
Pulmonary Rehabilitation	94625, 94626	5733	$56.85	$11.37
Individual Respiratory Therapy Services	G0237, G0238	5731	$25.23 (15 min. increments)	$5.05
Group Respiratory Therapy	G0239	5732	$34.57	$6.92